

**ANNUAL REPORT
OF THE
PSYCHIATRIC FACILITIES REVIEW BOARD**

**For the Year Ending
March 31, 1982**



Province of Nova Scotia
Psychiatric Facilities Review Board
P.O. Box, 2080 D.E.P.S., Dartmouth N.S. B2W 2Y8

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August 4th, 1983

The Honourable Gerald Sheehy, D.V.M.
Minister of Health
Province of Nova Scotia
P.O. Box 488
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Dear Sir:

I am pleased to submit herewith the third annual report of the Nova Scotia Psychiatric Facilities Review Board.

Respectfully submitted,

STEPHEN K. MONT, B.A., LL.B.
Chairman

PSYCHIATRIC FACILITIES REVIEW BOARD

PART I

ACTIVITIES

During the third year of operation, April 1, 1981 to March 31, 1982, the Board conducted thirty-nine automatic reviews under Section 56 of the Act. Of these six patients had their status changed from formal to informal.

The Board received nine requests for reviews under Section 57 of the Act. Of these one was cancelled because the patient had been made informal prior to the date set for the review. Of the remaining eight requests, hearings resulted in four patients having their status changed from formal to informal.

The Board conducted one hearing under Section 52 of the Hospitals Act to determine whether there had been compliance with the requirements of that Section before psychosurgery could be performed and the Board determined that the requirements had been complied with.

In addition the Chairman of the Board and Dr. R. O. Jones took part in a panel discussion sponsored by the Medical-Legal Society of Nova Scotia.

During the year Patrick Curran, a member of the Board, was appointed a Provincial Magistrate and therefore resigned from the Board. The Board wishes to thank Mr. Curran for the contributions he made to the Board during the past three years.

PART II

RECOMMENDATIONS AND CONCLUSIONS

In each of the previous reports, your Board has directed attention to several issues which in their opinion are detrimental to the optimal health care for the mentally ill of this Province. These same issues also are of importance to the relatives of patients and, indeed, to the community at large since, in the opinion of the Board, they frequently lead to patients who badly need psychiatric care being denied that care because they are not

considered physically dangerous, or to the patient, who has partially improved as a result of the care which he has experienced, being released from that care prematurely and suffering a serious relapse. Such incidences may, on the one hand, physically endanger the health or life of other members of the family and of the community; or, more likely, the family's well-being--emotional and economic--may be permanently impaired. The repeated mention of these issues has resulted in much public discussion by a number of interested and professionally concerned groups, but it has not yet resulted in any constructive changes in our present Mental Health Act.

The areas of concern which the Board refers to are as follows:

1. The requirements for formal status: Essentially, there are two--
 - (i) the presence of a psychiatric disorder;
 - (ii) immediate dangerousness to the patient or to others resulting from that psychiatric disorder.

We continue to feel focussing entirely on mental disease producing immediate physical danger to the patient or others is far too narrow a criteria for rendering a patient formal and the result is that clearly psychotic patients who would benefit from treatment do not receive such treatment because of the absence of immediate physical dangerousness. In these circumstances, the financial position, the reputation and the emotional stability of themselves, of their families, and occasionally of the community may suffer badly. Equally, such specific interpretation of the present wording often results in half-treated patients being completely discharged despite the fact that one predicts regression to the former state in a short time and return to a condition of dangerousness. Discouraged by such a relapse the patient may be more dangerous (that is, more suicidal) than he was before his aborted treatment. We then feel that there should be a period of parole, or a period of trial discharge, and that continuance of that informal status would be partially dependent upon compliance with whatever treatment appeared to be indicated. Your Board feels that the Board, the hospitals of Nova Scotia, the Department of Health and the Attorney General have been extremely fortunate in not having such a recently discharged patient commit a serious act of violence during the time that the Act has been in operation. We would again, urge

that, as part of a total survey of the Act after three years' experience with it, a study be made of the possibility of trial release being put into the Act.

2. The need for a small locked unit to care for a few very disturbed patients in the hospital system of Nova Scotia who are frequently placed in understaffed hospitals with no control being exercised beyond that which can be exercised by a handful of staff members. We have repeatedly seen one man in the Province who has serious mental disease and part of that mental disease is the compulsion to take any automobile which he can steal (and he has become very adept at stealing cars) and driving on the highways of Nova Scotia as fast as the car will go. He has already been involved in one accident which resulted only in property damage and not loss of life. We wonder what the legal position of that hospital would be if his mental disorder had led to him killing someone when he presumably was in safe custody. The only locked unit in the Province now is the Forensic Unit, and is not available for use by non-Forensic patients.

We again recommend, then, the setting up of a small locked psychiatric unit which would provide some control when needed for these exceedingly difficult, truly dangerous behaviour problems.

3. The issue of consent for treatment: Two points should be mentioned here:

- (i) The patient who is acutely ill and treatment is an urgent issue: The patient may refuse to give consent, or, more likely, he is so impaired by his psychiatric illness that he refuses on psychotic grounds. In some cases, there is no relative available and it is necessary for consent to be obtained from the Public Trustee; and the hospitals have informed us that this may take several days, during which the patient cannot be given any treatment--physical or mental--and no investigations can be performed. The result is an untreated patient who may deteriorate badly during that time or who may be such a management problem that he constitutes a danger to other patients, to staff or to the facilities that

he is in. The Board would feel that the Act should be changed to permit immediate treatment to such a patient when such emergency conditions exist and, if it is reasonable to delay and seek outside authority, that a study be made as to the possible advantage of making the Review Board responsible for this kind of decision.

- (ii) The need for some change in the Act with regard to consent for treatment: We have seen one patient, for example, who suffers from a long-standing paranoid illness which has gotten her into trouble with police forces in several parts of the country, which has seriously interfered with her life adjustment and which has caused immeasurable suffering to her parents whom she, in a paranoid way, believes to be responsible for all her troubles. This lady is obviously severely psychotic with paranoid delusions--she protests that she will never act on these delusions even though she believes she has a number of very hostile enemies who are a real threat to her future life. She has a preservation of her intellectual functioning which makes her able to put forward the views in a way which is very convincing to the listener. It is felt that there is good evidence that she would be dangerous if she left the hospital so it seems within the meaning of the Act the proper thing to do to keep her a formal patient and insist on further hospitalization, and yet while she is in the hospital it seems impossible to consider her as not being able to consent or refuse treatment. She had been on proper treatment for a period before the Board saw her--permission having been given by her parents--and has improved to the point where it was felt that it was proper that she either give or refuse consent. She refused consent, and the Board felt that she should still remain in hospital as a formal patient but felt that the treatment should not be continued since she did not consent to it. The result was progressive deterioration, and within the month we had to see her again and this time had no doubt that the criteria for treatment within the hospital had been adequately met and treatment ~~needed~~ with

Again, we feel that the Act should be reviewed, and it would be our recommendation that it should be modified so that treatment could be continued in the kind of situation we have described.

These recommendations are not new, for they appear implicitly or explicitly in the previous reports of your Board; and they have been spelled out in very considerable detail in discussions with a number of interested and knowledgeable groups within the Province. What is new and what the Review Board would like to bring to the attention of the Departments concerned is the wide amount of support which has come from a variety of unrelated sources to attest to the continent-wide interest in these particular recommendations and to the fact that many informed and progressive people are thinking along the same lines. In support of this statement, we would offer the following:

1. A report prepared by an expert committee of the Nova Scotia Psychiatric Association under the chairmanship of Dr. S. N. Akhtar which has exhaustively studied the Mental Health Act in general and these issues in particular. This has been presented to the Association and while the exact wording has not been worked out by the Association, the Report has been accepted in principle as a valid statement of the Association's position. The recommendations of this Committee are: "that the Act should be broadened to include people who are so disabled by their mental illness that they are unable to look after their basic needs--that is, they are passively dangerous to themselves." They also agree with the principle of gradual return of psychiatric patients to the community and recommend that "a formal patient could be out of the hospital for a two-week trial period and that, in appropriate cases, this pre-release period should be up to three months--this action being taken only with the prior approval of the Review Board." They would also recommend a change in the obtaining of consent, suggesting that "the Review Board should be authorized to consent or refuse treatment on behalf of patients who are incapable and where the next-of-kin cannot be easily contacted." As already mentioned, the Association has approved

the spirit of these recommendations and not the actual wording. They also feel that physicians should be authorized to administer "basic care to formal patients held for psychiatric assessment where such would appear to be necessary, without the necessity of informed consent." This would include such things as the treatment of injuries, medicine (for example, for gastro-intestinal discomfort or for headache), etc. Again, they would recommend that the Review Board could override a formal patient's competent consent to treatment if they believed it was in his best interest.

2. The second source of information comes from the recent meeting of the American Psychiatric Association. This meeting was opened by an address by Mayor Koch of New York who told those in attendance that there were 5,000 patients discharged from the mental hospitals who did not satisfy the criteria for dangerousness who were sleeping on the sidewalks of New York every night. In January, 1983, one of these patients--an elderly lady sleeping in a packing box on a New York street--froze to death while legal proceedings were being instituted for her admission to hospital. This was followed by the prestigious Guttmacher Lecture given by two young men who were both psychiatrists and lawyers who sketched the move in the care of mental patients from the old fraternalism, when doctor and authority knew best, to the present legalism, where making sure that the right procedure was followed to protect the patient's rights became more important than meeting the patient's needs. They characterized the present era as one in which we were more concerned with the process that we went through rather than the results of that particular process. We would suggest that this statement does accurately represent the condition of much mental health legislation around the World.
3. Finally, there is much movement in other Canadian provinces where the same sort of difficulties are emerging. An article in the December 1982 issue, Volume 7, No. 4, of the Psychiatric Journal of the University of Ottawa, reports the present workings in the Province of Ontario. In

1979, the Ontario Council of Health reported "We are concerned that the present legislation excludes the physical destruction of property, the wasting of assets and severe emotional damage to the immediate family" and goes on "We do not feel the present emphasis on bodily harm is adequate to deal with all serious psychiatric emergencies which arise from mental disorder. We feel that a simpler test which will give the practitioner greater flexibility is in the interest of the individual, the family and society at large." Despite the amendment of the Ontario Act in 1978 which broadened the definition, stating that "if a practitioner had reasonable cause to believe that the person, (a) had threatened or attempted or was threatening or attempting to cause bodily harm to himself, (b) has behaved or is behaving violently towards another person who has caused or is causing another person to fear bodily harm from him, or, (c) has shown or is showing a lack of competence to care for himself", he could be admitted as a formal patient. Apparently, the Ontario Council of Health feels that this is still not broad enough and recommends further study.

One could go on with similar quotes from informed sources in many parts of the English-speaking world. All of these have the same intent: (a) to broaden the definition of dangerousness to include a good deal more than actual physical harm and to allow formal admission and treatment of patients with serious psychiatric illness who could benefit from such treatment and who are likely to suffer themselves or cause marked suffering and deterioration in those around them if treatment is not provided; (b) to try to ensure that treatment should be carried to completion and not be almost automatically stopped once the patient has momentarily moved from the position of being not strictly a formal patient; (c) to provide adequate facilities and staff for those mental health workers who are entrusted with the care and supervision of formal patients; (d) to have many of these advances supervised by an outside, presumably non-biased and non-prejudiced body such as the Mental Health Review Board.

We would point out that the addition of many of these duties to the Review Board would demand a good deal more time being spent by this body than currently exists. (It should be noted that your Board currently does much more

than the Boards of the other Atlantic Provinces. For example, in New Brunswick, the Mental Health Review Board last met in April and will hold another meeting in November.) However, if the feeling in the populace of Nova Scotia is sufficiently supportive of the needs for such regulation by the Mental Health Review Board, this presumably could be solved by adding members or perhaps setting up Boards in other areas of the Province besides Halifax. The Review Board would like to mention that this really is a costly process and one should wonder if the risk to the civil liberties of the patients are really so great that the funds devoted to enlarging the scope of the Review Board are better expended in that direction than in added treatment facilities.

CONCLUSION

Our major recommendation at this moment, then, is that after almost four years of operation, it is time to launch a re-evaluation of our Hospital Act as it applies to mental hospitals with the object of finding what works and what does not work and trying to shift the balance in the direction of the necessary and workable solutions.